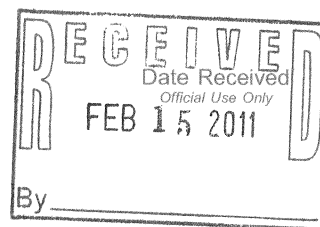


STATEMENT OF ECONOMIC INTERESTS
COVER PAGE



Please type or print in ink.

NAME OF FILER (LAST) (FIRST) (MIDDLE)
Vuori Kristiina

1. Office, Agency, or Court

Agency Name

CA Institute of Regenerative Medicine (CIRM)

Division, Board, Department, District, if applicable

Your Position

Independent Citizen's Oversight Committee (ICOC)

ICOC Member

► If filing for multiple positions, list below or on an attachment.

Agency: _____ Position: _____

2. Jurisdiction of Office (Check at least one box)

☒ State ☐ Judge (Statewide Jurisdiction)
☐ Multi-County _____ ☐ County of _____
☐ City of _____ ☐ Other _____

3. Type of Statement (Check at least one box)

☐ Annual: The period covered is January 1, 2010, through December 31, 2010.
-or-
The period covered is ____/____/____, through December 31, 2010.
☒ Assuming Office: Date 01 / 27 / 11
☐ Leaving Office: Date Left ____/____/____
(Check one)
☐ The period covered is January 1, 2010, through the date of leaving office.
☐ The period covered is ____/____/____, through the date of leaving office.
☐ Candidate: Election Year _____ Office sought, if different than Part 1: _____

4. Schedule Summary

Check applicable schedules or "None."

► Total number of pages including this cover page: 3

☐ Schedule A-1 - Investments - schedule attached
☐ Schedule A-2 - Investments - schedule attached
☐ Schedule B - Real Property - schedule attached
☒ Schedule C - Income, Loans, & Business Positions - schedule attached
☐ Schedule D - Income - Gifts - schedule attached
☒ Schedule E - Income - Gifts - Travel Payments - schedule attached
-or-
☐ None - No reportable interests on any schedule

5. Verification

MAILING ADDRESS STREET CITY STATE ZIP CODE
(Business or Agency Address Recommended - Public Document)
[Redacted] La Jolla CA [Redacted]
DAYTIME TELEPHONE NUMBER E-MAIL ADDRESS
[Redacted] [Redacted]

I have used all reasonable diligence in preparing this statement. I have reviewed this statement and to the best of my knowledge the information contained herein and in any attached schedules is true and complete. I acknowledge this is a public document.

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date Signed 2/8/11
(month, day, year)

Signature [Redacted]

CALIFORNIA FORM 700 FAIR POLITICAL PRACTICES COMMISSION	
Name Kristiina Vuori	

▶ 2. LOANS RECEIVED OR OUTSTANDING DURING THE REPORTING PERIOD

NAME OF LENDER* _____ ADDRESS <i>(Business Address Acceptable)</i> _____ BUSINESS ACTIVITY, IF ANY, OF LENDER _____ HIGHEST BALANCE DURING REPORTING PERIOD <input type="checkbox"/> \$500 - \$1,000 <input type="checkbox"/> \$1,001 - \$10,000 <input type="checkbox"/> \$10,001 - \$100,000 <input type="checkbox"/> OVER \$100,000	INTEREST RATE _____% <input type="checkbox"/> None SECURITY FOR LOAN <input type="checkbox"/> None <input type="checkbox"/> Personal residence <input type="checkbox"/> Real Property _____ <div style="text-align: right;"><i>Street address</i></div> <div style="text-align: right;">_____</div> <div style="text-align: right;"><i>City</i></div> <input type="checkbox"/> Guarantor _____ <input type="checkbox"/> Other _____ <div style="text-align: right;"><i>(Describe)</i></div>
--	--

Comments: _____

SCHEDULE E
Income – Gifts
Travel Payments, Advances,
and Reimbursements

CALIFORNIA FORM 700 FAIR POLITICAL PRACTICES COMMISSION
Name <div>Kristiina Vuori</div>

- **Reminder – you must mark the gift or income box.**
- **You are not required to report income from government agencies.**
- **You may mark the box 501(c)(3) for a travel payment received from a nonprofit 501(c)(3) organization. When the payment is a gift it is reportable but is not subject to the \$420 gift limit.**

▶ NAME OF SOURCE	
American Association for Cancer Research	
ADDRESS (Business Address Acceptable)	
615 Chestnut St, 17th Floor	
CITY AND STATE	
Philadelphia, PA 19106-4404	
BUSINESS ACTIVITY, IF ANY, OF SOURCE	<input type="checkbox"/> 501 (c)(3)
DATE(S): 03 / 05 / 10 - 03 / 10 / 10 AMT: \$ 1,838.18	
(If applicable)	
TYPE OF PAYMENT: (must check one) <input type="checkbox"/> Gift <input checked="" type="checkbox"/> Income	
DESCRIPTION: Travel Reimbursement for speaking at 2nd AACR International Conference	

▶ NAME OF SOURCE	
Markey Cancer Center	
ADDRESS (Business Address Acceptable)	
800 Rose St, CC144B	
CITY AND STATE	
Lexington, KY 40536-0093	
BUSINESS ACTIVITY, IF ANY, OF SOURCE	<input type="checkbox"/> 501 (c)(3)
DATE(S): 09 / 21 / 10 - 09 / 22 / 10 AMT: \$ 865.45	
(If applicable)	
TYPE OF PAYMENT: (must check one) <input type="checkbox"/> Gift <input checked="" type="checkbox"/> Income	
DESCRIPTION: Travel Reimbursement for attending Markey Cancer Center External Advisory Board Meeting	

▶ NAME OF SOURCE	
ADDRESS (Business Address Acceptable)	
CITY AND STATE	
BUSINESS ACTIVITY, IF ANY, OF SOURCE	<input type="checkbox"/> 501 (c)(3)
DATE(S): ____ / ____ / ____ - ____ / ____ / ____ AMT: \$ ____	
(If applicable)	
TYPE OF PAYMENT: (must check one) <input type="checkbox"/> Gift <input type="checkbox"/> Income	
DESCRIPTION: _____	

▶ NAME OF SOURCE	
ADDRESS (Business Address Acceptable)	
CITY AND STATE	
BUSINESS ACTIVITY, IF ANY, OF SOURCE	<input type="checkbox"/> 501 (c)(3)
DATE(S): ____ / ____ / ____ - ____ / ____ / ____ AMT: \$ ____	
(If applicable)	
TYPE OF PAYMENT: (must check one) <input type="checkbox"/> Gift <input type="checkbox"/> Income	
DESCRIPTION: _____	

Comments: _____